Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JIM SHER DC
4151 SW FREEWAY STE 750
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
CITY OF HOUSTON

Carrier's Austin Representative Box
Box Number 29

MFDR Tracking Number
M4-07-3445-01

MFDR Date Received
JANUARY 29, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Preauth Obtained"

Amount in Dispute: $1,493.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The response to the request for medical fee dispute resolution did not contain a position summary.

Response Submitted by: Harris & Harris, 5700 Southwest Parkway, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2006 through January 23, 3006	Physical Therapy Services	$779.00	$0.00
January 30, 2006 through February 15, 2006	Physical Therapy Services	$714.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.301 sets out the guidelines for retrospective review of medical bills.
3. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 16 – Not all info need for adjudication was supplied.

- D19 – Claim/service missing supporting documents.
- 50 – Service not deemed 'Medically Necessary' by payer
- W1 – Workers' Compensation State Fee Schedule adj
- W12 – Extent of Injury. Not finally adjudicated.

Issues

1. Was the request for medical fee dispute resolution filed to the Division timely?
2. Did the Requestor obtain preauthorization for the billed services and submit medical records to support the services were rendered as billed?

Findings

1. 28 Texas Administrative Code §133.307(c) states "Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A)A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. Subparagraph (B) states that a request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability..." Although the respondent used denial code W12 – "Extent of Injury not adjudicated", review of the documentation submitted by both parties finds there are no unresoslved extent of injury or compensability issues.

   The requestors' submitted DWC-60 was received by the Division on January 29, 2007. The dates of service listed on the table of disputed services range from January 6, 2006 through February 15, 2006. In accordance with §133.307(c)(1) dates of service January 6, 2006 through January 23, 2006 were submitted untimely and will not be reviewed. The remaining dates of service, January 30, 2006 through February 15, 2006 will be reviewed in accordance with Division Rules and the Texas Labor Code.

   Review of documentation submitted by the requestor finds that on March 19, 2007 the requestor withdrew date of service February 15, 2006 and on April 26, 2007 the requestor withdrew CPT Code 97032 for dates of service February 1st, February 6th, February 8th and February 10th of 2006. These dates of service will not be included in the review of this medical fee dispute resolution request.
2. In accordance with 28 Texas Administrative Code §134.600(h)(15),effective Date of November 3, 2005 and expiring March 2, 2006, states that The non-emergency health care requiring preauthorization includes: physical and occupational therapy services rendered on or after December 1, 2005.(A)Physical and occupational therapy services are those services listed in the Healthcare Common Procedure Coding System (HCPCS) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i)Modalities, both supervised and constant attendance; ii)Therapeutic procedures, excluding work hardening and work conditioning; and (iii)Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code. Review of the preauthorization approval finds that CPT Code 97110 was the only code that was preauthorized; therefore, documentation does not support preauthorization was obtained for CPT Code 97032 for date of service January 30, 2006 and CPT Code 97124 for dates of service January 30, 2006 through February 8, 2006. As a result the amount order is $0.00

   The carrier denied CPT Code 97110 using the denial code 50 - "service not deemed a 'medical necessity' by the payer." In accordance with Texas Administrative Code Section 133.301(a), which states in part, "...The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134..." The health care provider submitted a copy of the preauthorization approval number WRIG12092005001. The above denial reason is not support. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

   In accordance with 28 Texas Administrative Code §133.307(e)(2), the Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules. Review of the documentation submitted by the requestor finds that the requestor did not submit medical records to support the services were rendered as billed. As a result the amount ordered is $0.00.

   The carrier denied CPT Code 97110 for date of service January 30, 2006 using denial code 16 – "Not all info needed for adjudication was supplied" and D19 – "Claim/Service missing supporting documents." Review of the documentation submitted by the requestor finds the requestor did not include medical records to support the service was rendered as billed. As a result the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 22, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.